DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES
Emergency Medical Services Office
123 Chalan Kareta
Mangilao, GUAM 96913-6304
(671)735-7407 FAX (671) 735-7413

FOR OFFICE USE

INSTRUCTOR vjq11807/120514
Galaide82415

Date Received & By: _____

Date Reviewed & By: _____

/ / Approved / / Disapproved

_____
EMS Medical Director
Date: _____

/ / INSTRUCTOR
/ / Certification
/ / Re-Certificaiton

/ / INSTURCTOR AIDE
/ / Certification
/ / Re-Certification

Level
/ / EMT
/ / AEMT
/ / EMT-Paramedic
/ / EM Dispatch
/ / Physician
/ / Physician Asst.
/ / Registered Nurse

COMMENTS: _____

Application for Instructor/Instructor Aide

Please Type or Print (Use Black or blue ink ONLY)

A. IDENTIFICATION: ( ) Mr. ( )Miss ( ) Mrs. ( )Ms. ( )Dr.

1. **Name:** _____
LAST FIRST MIDDLE MAIDEN
2. **Email Address:** _____ **Birth date:** _____ **SSN:** _____
3. **Mailing Address:** _____
P.O. Box Number City State Zip Code
4. **Home Address:** _____
Street Name & Number City State Zip Code
5. **Home Phone:** _____ **Radio/Cell Phone:** _____ **Other Contact #** _____
6. **Guam EMT Certification No:** _____ **Expiration Date:** _____

B. EMPLOYMENT:

1. Occupation: _____ Work Phone: _____ Extension: _____
2. Employer/Agency/Organization: _____
3. Employer's Address: _____
P.O. Box Number City State Zip Code

Please Continue on Reverse Side

C. Application Request:

Instructor:	**Instructor Aide:**
/ /Certification	/ /Certification
/ /Re-Certification	/ / Re-Certification

D. **Applicant Level:**

/ /EMT	/ /Physician
/ /AEMT	/ /Physician Asst
/ /EMT-Paramedic	/ /Registered Nurse
/ / EM-Dispatch	

E. Please complete the attached forms:

1. ADDENDUM A, Ref: Pre-hospital Care Experiences
2. ADDENDUM B, Ref: Teaching Experiences

I understand that my application will not be accepted for processing until it has been completed in its entirety and I hereby affirm and declare that the above information is true and correct and that any fraudulent entry may be considered cause for rejection or subsequent revocation. It is also understood that the Guam EMS Office may conduct an audit of the registration activities reported on these forms at any time.

Applicant's Signature **Date**

ADDEMDUM – A

Pre-Hospital Care Experiences

Applicant's Full Name: _____ **EMT No:**_____

NOTE: For verification purposes, please give COMPLETE location's name and address. Also attach all copies of certifications, resume, etc. Otherwise, application will not be processed.

Delivery of Pre-hospital Care Experiences:

Location's Name and Address:

Dates:

Delivery of Pre-hospital Care Experiences:

Location's Name and Address:

Dates:

Delivery of Pre-hospital Care Experiences:

Location's Name and Address:

Dates:

Delivery of Pre-hospital Care Experiences:

Location's Name and Address:

Dates:

ADDEMDUM – B

Teaching Experiences

Applicant's Full Name: ______________________________ EMT No:_____________________

NOTE: For verification purposes, please give COMPLETE location's name and address. Also attach all copies of certifications, resume, etc. Otherwise, application will not be processed.

Area of Specialty:____

____

Name of Topic/Subject: ____

Please Indicate: / /Instructed / /Assisted / /Both

Location's Name and Address: ____

____

____

Dates: ____ **Hours:**______________

****

Area of Specialty:____

____

Name of Topic/Subject: ____

Please Indicate: / /Instructed / /Assisted / /Both

Location's Name and Address: ____

____

____

Dates: ____ **Hours:**______________

****

Area of Specialty:____

____

Name of Topic/Subject: ____

Please Indicate: / /Instructed / /Assisted / /Both

Location's Name and Address: ____

____

____

Dates: ____ **Hours:**______________

****

Area of Specialty:____

____

Name of Topic/Subject: ____

Please Indicate: / /Instructed / /Assisted / /Both

Location's Name and Address: ____

____

____

Dates: ____ **Hours:**______________

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